Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001135	A. BUILDING: _____ B. WING _____	03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON RESIDENCE OF FORT WAYNE	7515 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey date: March 20, 2013 Facility number: 001135 Provider number: 001135 AIM number: N/A Survey team: Sue Brooker RD TC Julie Call RN Virginia Terveer RN Census bed type: Residential: 56 Total: 56 Census payor type: Other: 56 Total: 56 Sample: Residential sample: 7 Kingston Residence of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 03/21/13 by Lisa McColly	R 000		